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PREFACE

Change in the delivery of today's health care is occurring at a rate that makes it almost impossible to keep up. Many of the clinical services and functions previously provided on an inpatient setting now take place in the ambulatory setting. Within the Army Medical Department (AMEDD), many of the smaller inpatient facilities have transitioned to health care centers or clinics. Nurses face role challenges as health promotion advocates, care managers/coordinators, community/patient advocates, outcome managers and health educators, to name a few. With this transformation of roles comes the requirement for new skills and knowledge critical to ambulatory care nursing.

On 7-8 August 1997, the Ambulatory Care Task Force convened in San Antonio, Texas, to identify the core knowledge and skills necessary for the nurse to successfully transition from the inpatient setting to an ambulatory care setting. The initial draft of this ambulatory care primer was created and presented to the Chief of the Army Nurse Corps and other Army Nurse Corps (AN) leaders in late August 1997. The primer was updated in June 2000.

Based on recommendations from AMEDD nurses worldwide and various AN consultants, the primer was refined by a small ad hoc group assigned to Fort Sam Houston. The final product, a self-directed developmental guide titled *Managing Care in an Ambulatory Environment*, is contained in the pages that follow. This document is designed for the reader to be an active participant in the collaborative process that facilitates learning and interfacing with relevant personnel throughout the organization.

A heartfelt "thank you" is extended to the individuals of original task force for their contributions to making this primer a reality. Without the hard work of the group, this would not have been possible. Thanks, also to you the reader for all you do on a daily basis to foster the delivery of superb health care to our soldiers and their families.

Army Nurse Corps -- Ready, Caring and Proud

SECTION I. TRANSITION TO AMBULATORY CARE

❑ INTRODUCTION

Managing the delivery of care in the tumultuous environment that currently exists within the Military Health System (MHS) is not just a clinical challenge; it is a business challenge as well. To be successful in these turbulent times, one must possess both clinical skills appropriate to the health care needs of the beneficiaries served and significant business acumen. An in-depth knowledge of your health care system, at the organizational and at the unit or work center levels, is crucial to maximize your contribution to the delivery of care and services.

This manual is intended to facilitate your transition into the role of an effective and versatile care manager in the ambulatory setting. It was designed to serve as a resource and compliment the hospital and unit-specific orientations that are already in place in your organization. The information you will obtain in response to the questions posed will be comprehensive, perhaps even overwhelming at first glance. If all this material does not appear to be relevant at this point in your experience, you can return later when the usefulness of the information will become more apparent.

The intent of the work group that developed this manual was to provide information to assist personnel newly assigned to an ambulatory setting. The authors wish you great success as you enter and assimilate into this exciting practice area--one that is filled with possibility and challenge.

❑ PROFESSIONAL PRACTICE REORIENTATION

Professional practice in the ambulatory setting offers a broad range of opportunities for significant nursing contribution to the care of our beneficiaries. The duties, responsibilities, and expectations of the ambulatory setting are noticeably different from those of patient care delivery in the inpatient setting. Nurses assume multiple roles including managing clinic activities, coordinating patient services, planning and providing care, providing technical assistance, and supervising clerical and technical staff.

Successful transition to an ambulatory care frame of reference can take a great deal of time if done by trial and error or given an unstructured orientation to the challenging demands of this work setting. A systematic and focused approach to the information, as presented in the pages that follow, hopefully will facilitate the learning of those assigned in any ambulatory care setting, regardless of the patient population(s) served.

An excellent starting point for your transition to an ambulatory perspective is to read the publication by the American Nurses Association (ANA) titled *Nursing in Ambulatory Care--The Future is Here*. This booklet provides a broad yet concise view of the ambulatory setting with its unique challenges and possibilities for professional nursing influence. This publication defines ambulatory nursing as: *" Professional ambulatory*

care nursing includes those clinical, management, educational, and research activities provided by registered nurses for and with individuals who seek care for health-related problems or concerns or seek assistance with health maintenance and/or health promotion . . .services are episodic, less than 24 hours in duration, and occur as a single encounter or series of encounters over days, weeks, months or years." (ANA).

An additional reference, which also merits your attention, is the American Academy of Ambulatory Care Nursing (AAACN) publication, *Ambulatory Care Nursing Administration and Practice Standards.* These standards are valuable guides in directing and monitoring practice in the ambulatory setting and can help identify existing or potential situations that merit professional nursing attention and intervention.

A reference list is provided in Section VI of this manual for further reading about professional issues and challenges associated with ambulatory practice.

SPECIFIC PRACTICE ISSUES IN AMBULATORY CARE

Mission/ Scope of Services

The two questions most commonly asked by personnel new to the ambulatory setting are "Where do I start?" and "What exactly is my job/role here?" The answers to these questions depend upon the mission and scope of services in the specific clinic as well as the location of the clinic. The following information should help to guide you in your initial assessment of patient requirements and the services provided in your work setting. Once the assessment is complete, you can then prioritize the issues or problems and decide where to begin with system changes or improvements.

In the ambulatory setting, the registered nurse's (RN) attention and purpose must include both the individual health care beneficiary (HCB) and the community. This requirement is addressed in the following excerpt from the *AAACN Standards of Practice.*

> ***STANDARD IV**, Ambulatory Nursing Practice:*
>
> ***Standard:** The nursing process is the foundation used by professional ambulatory care nurses in making clinical decisions as they assess and identify patient health status, establish outcomes, plan, implement and evaluate the care the provide.*
>
> ***Rationale:** Nursing practice in ambulatory care is diverse, encompassing a multitude of specialty practice settings. Every patient seen in ambulatory care may not require professional nursing services. Professional registered nurses practicing in ambulatory care have the expertise, skills, and responsibility to systematically assess patient needs and ensure the delivery of nursing services that meets patient care requirements.*

Criteria 1*: Professional ambulatory care nurses, along with the health care team, may use two levels of assessment in the ambulatory care setting:*

- *General assessment of a patient for basic risk factors and reason for visit.*
- *Management of the individual patient or groups of patient needing professional nursing care, involving the registered nurse using a second level of assessment to determine individual patient needs.*

The idea conveyed here is the foundation of nursing practice in the ambulatory setting. The professional nurse must ensure that patients who require nursing involvement in their care are provided this service. Patients are often seen by the RN only for crisis intervention or for oversight of a technical procedure. Instead, there must be a planned, systematic process in place for referral to the nurse, as appropriate. Helping to design a care delivery system in your setting that facilitates planned nursing intervention and focuses on health promotion and disease prevention is one of your primary responsibilities.

Population Based Care Planning

By learning the health care needs of a specific population, clinics can tailor their services to those needs. Population health involves clinical preventive services for healthy people and secondary follow-up preventive care for people who already have disease. To learn about population needs and identify specific risk factors, TRICARE prime enrollees must complete the Health Enrollment Assessment Review (HEAR).

The RN plays a vital role in planning care for groups of patients while considering the individual needs of each client. Programs and processes that address the needs of high volume, high risk, high cost, or problem prone patients, must reflect the limitations imposed by the short duration of contact between provider and individual patient. Disease management is outcome/patient based, uses the best practices and eliminates variances and reduces cost. Planning care for populations of patients may include activities such as the use of clinical pathways, case management of selected client groups, or diagnosis-based referrals for focused patient education. This group approach helps to manage the majority of patients with similar needs. Other patients will need individualized intervention and planning.

The RN is responsible for planning the patient's care needs, not necessarily for meeting them all. Many services are available within the hospital and the community which are designed to meet your patients' education or support needs. It is important for you to be aware of these available services and how to access them, and to ensure that appropriate referrals are made. In some cases, follow-up to assess the effectiveness of the referred care is appropriate. Population health improvement supports data driven disease management and prevention programs to effect positive changes in the health of a given population. In assessing the needs of the population served in your ambulatory setting, consider the following questions:

- What is the population being served by your Medical Treatment Facility (MTF)?
- How many HCBs are eligible for care within your catchment area?
- What are the demographics of this population?
- Is there another military MTF collocated in your catchment area? What sort of memorandum of understandings (MOUs) exists between your organization and the other facility?
- What is your role in dealing with both military and civilian communities? (The community beneficiary survey will help with this. Your Resource Management Directorate (RMD) will have documents that describe the beneficiary population within your catchment area.)
- Is it appropriate to expand your interaction with the military and/or civilian communities?

Example

An example to illustrate this approach to patient care planning is provided below.

- Evaluation of the population. A family practice clinic evaluates the population served and determines that the following are its primary population groups:

  - Over 65 years
  - Mature adults
  - Adults of childbearing age
  - Adolescents
  - General pediatrics

- Categorization of needs or diagnoses. Within each group noted above, there are relevant patient needs or diagnoses that can be categorized as high volume, high risk, high cost, and problem prone. All four categories may not apply to each patient group.

- Determination of health maintenance/disease prevention needs. The next step is to determine the health maintenance/disease prevention needs of each group. This assessment provides the basis for:

  - Educational program development
  - Structuring clinic hours to meet patient requirements
  - Other decisions related to care, screening services, HEAR/PHCA, case management, and disease management

Family practice staff collaboration during this step of the patient care planning process resulted in the establishment of a mechanism for patient referral by the privileged providers to nursing staff. Selected patients are automatically directed to the nursing staff for patient-unique education, follow-up, or case management.

These referrals avoid the unnecessary use of provider appointment time for care that quite appropriately can be provided by the nursing staff. In addition, this approach helps to ensure that patient education and case management occur by design rather than by accident.

In our example, the following may represent the primary diagnoses (available in the Ambulatory Data System [ADS] or through Patient Administration Division-[PAD]) for the pediatric population:

- Well-child/immunization visits
- Otitis media
- Upper respiratory infection
- Asthma
- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
- At risk for abuse/neglect

- Care planning. The planning of care for the asthmatic group should include an automatic referral to a nurse for all newly diagnosed asthmatics and a teaching program which reviews at each visit-–the disease process, medications, home care, school issues, and any special concerns. There is an established DOD Clinical Practice Guideline (CPG) for asthma that should be used. The care plan may include, as needed: referral to a patient support group for parents or child (or the establishment of such a group); follow-up visits to ensure proper use of medications and an evaluation of the child's progress; and liaison between other services/support groups and the clinic for feedback on medical, nursing, or counseling intervention.

  The population based care planning approach allows the RN to plan care for groups of patients and establish system supports to ensure effective management of care with timely, appropriate intervention and follow-up. This is similar to the structured programs in place for inpatient populations such as diabetic or cardiac patients. The challenges created by short outpatient visits with limited staff access to patients make implementation of these worthwhile programs and services in the ambulatory setting critical to quality healthcare.

SECTION II. HEALTH PROMOTION AND WELLNESS

❑ INTRODUCTION

The **ultimate weapon--**the soldier--and family are key to the mission of the U.S. Army; and keeping them healthy is a primary goal of health promotion practitioners. The Directorate of Health Promotion and Wellness (DHPW) at the United States Army Center for Health Promotion and Preventive Medicine (USACHPPM) interacts with a host of individuals, professionals, nonprofessionals, and agencies at levels throughout the Department of Defense (DOD) to move them toward a greater understanding of the principles and practices of health promotion. Furthermore, DHPW employs professional staff officers including: Army community health nurses, dietitians, physical therapists, health educators, social workers, and others to accomplish this mission. These multidisciplinary practitioners in DHPW accomplish their mission by identifying priorities and areas to focus their attention, based on guidance from higher headquarters and the Army Health Promotion Regulation, AR 600-63. These priority areas are:

- Injury prevention.
- Decrease tobacco use.
- Decrease Sexually Transmitted Diseases (STDs).
- Increase health screening and immunizations.
- Maintain healthy weight and nutritional status.
- Increase stress management skills.
- Decrease alcohol use.
- Decrease workplace and family violence.
- Increase emphasis on suicide prevention.
- Increase emphasis on spiritual fitness.

The staff officers of DHPW at the USACHPPM may provide customer service to health promotion coordinators, community health nurses, or ambulatory nurses at any MTF. These services may include consultation and subject matter expertise on a number of health promotion and prevention subjects. Requests for assistance may be made electronically at DHPW@apg.amedd.army.mil, or telephonically at commercial (410) 436-4656 or DSN 584-4656. A DHPW staff person will take the information and forward it to the proper staff officer, following which the customer will be contacted by electronic mail or telephonically.

Health Promotion and Wellness – Key Questions

- Has a recent community health care needs assessment been performed?
- What were the results of this assessment?
- Are any changes to your health promotion program forthcoming, as a result of this health needs survey?
- How do you utilize your HEAR program information?
- How was your Put Prevention Into Practice (PPIP) program implemented?
- Who is the point of contact (POC)?

- What is the role of the Community Health Nurse (CHN) in the assessment and implementation process?
- What are the implications for the organization? For your clinic?
- What programs are in place? Planned?
- What outreach wellness programs exist?
- How are the programs advertised? Who is responsible for marketing these programs?
- Is there any incentive to enroll in a health promotion/maintenance program?
- How does the health care beneficiary access available programs?
- Is there any coordination between the health promotion programs offered by your organization and available community programs and resources?

❑ HEALTH PROMOTION IN ACTION

An example for using DHPW to establish a health promotion center and using DHPW products is provided below:

1. Identify what currently exists and coordinate services through information sharing (internal and external).

    a. Command agreement and support is essential.
    b. Human resources -- transitioning from acute care to prevention, use CHN, dietitian, physical therapist, Morale Welfare and Recreation (MWR) staff, and other personnel to provide classes and other services.
    c. Needs assessment -- health promotion coordinator, CHN, or other designated personnel will have population health data to identify areas that need immediate attention to effect change in physical, behavioral, spiritual, or mental status to improve the health of the population. Data sources available at MTFs include: HEAR data, Preventive Health Care Application (PHCA), Composite Health Care System (CHCS), questionnaires, focus groups, and CHN biannual community assessment. (The DHPW services at USACHPPM that can assist in this area are Evaluation and Outcomes Service and Managed Care Service.)

    2. Be creative.

        a. Determine if a wellness center is needed or if coordination of wellness services can be done at MWR, Preventive Medicine, a designated room, or other area.
        b. Transfer equipment, furniture, personnel, volunteer services, and other resources (develop a business plan).

    3. Designated programs.

        a. Use outcome information of needs assessment to determine programs that are most needed.

b. Identify what services will be provided.
   (1) One stop shopping for prevention.
   (2) Marketing.
      (a) Use media department at MTF.
      (b) Use USACHPPM resources through DHPW.
      (c) Technical Army Support Center.
      (d) Post newsletters, paper.
      (e) Health fairs.
      (f) MWR resources such as newsletters, magazines.
      (g) Commissary.
      (h) Soldier in-processing.

4. Establish goals with an evaluation component incorporated.
   a. Identify metrics that will be evaluated.
   b. Identify personnel who will be able to assist in your programs.
      (1) Resource management personnel.
      (2) Utilization management.
      (3) DHPW (Evaluation and Outcomes Service).

❑ PREVENTIVE HEALTH CARE APPLICATION

The Preventive Health Care Application (PHCA) is an automated system which provides support to clinicians for improving the delivery and tracking of Clinical Preventive Services (CPS). The requirements of PHCA are predicated on the U.S. Preventive Services Task Force guidelines for CPS. This tool generates recommendations based on these guidelines and on integrated clinical information (Composite Health Care System (CHCS), Immunizations, and HEAR 2.0) and displays them on the provider's computer screen. With PHCA, this data can be accessed and used to assess the health status of the client and population as a whole. PHCA is an interim solution, pending the deployment of CHCS II. Once deployed, CHCS II is projected to maintain the same prevention-focused functions performed by PHCA.

The PHCA can have a positive impact on performance and tracking of CPS for MTFs that use it. It allows the MTF to track and flag individuals who may need preventive interventions. Moreover, this tool improves the provider's ability, clinically to Put Prevention Into Practice and it provides easy access to guidelines for the provider on prevention measures. The PHCA has capabilities to capture and track immunization data once the data is input.

Use the following web sites for additional information on PHCA, PPIP, and to other links.

The website http://odphp.osophs.dhhs.gov is for the Office of Disease Prevention and Health Promotion, Office of Public Health and Science, Office of the Secretary, U.S. Department of Health and Human Services (HHS). This agency works to strengthen the disease prevention and health promotion activities of the departments within HHS.

This online website offers current publications to include prevention reports and announcements, and works to strengthen the disease prevention and health promotion priorities of the Department within the collaborative framework of the HHS agencies.

The http://chppm-www.apgea.army.mil/dhpw/default.htm is the online website for the DHPW, USACHPPM. The website offers health information, publications, funding and resources to customers on ways to maintain and sustain a healthy and fit force by integrating health promotion into the total Army. The six sections in DHPW include the Office of the Director, Fitness and Nutrition, Education and Training, Managed Care, Behavior Health, and Evaluation and Outcomes. Customers who visit the DHPW web site will find links to other health related sites.

The http://www.phso.brooks.af.mil/hear1/hear1sc.htm is the website for the Office for Prevention and Health Services Assessment **(**OPHSA) is the Air Force on line website. The site provides information on health promotion, prevention and other health issues to include: Primary Care Optimization, Population Health Improvement-Priority Areas, HEAR.

The http://cba.ha.osd.mil/projects/fhp/phca/phca-main.htm is the website for the Clinical Business Area (CBA). CBA provides information about the clinical information systems currently under construction or complete for the Military Health System. Systems include information on the Composite Health Care System II (CHCS II); Military Computer-based Patient Record (CPR), Defense Dental Standard Application (DDSA), Government Computer-based Patient Record Framework (G-CPR), Preventive Health Care Application (PHCA), Personal Information Carrier (PIC), and Tri-Service Systems.

The http://odphp.osophs.dhhs.gov/pubs/hp2000/default.htm is the web site that contains historical records of the Healthy People 2000 objectives. Resources include Progress Review Reports, listings of the Consortium members, Consortium Exchange, the quarterly newsletter and much more. Healthy People is the prevention agenda for the nation.

The http://www.ahrq.gov/ppip/ is the online website for PPIP. This site provides background information on PPIP—including why it is needed, how it was developed, how PPIP is being used across the country and information on ordering PPIP resource materials.

The http://www.fedstats.gov/ is an online web site, which provides information about a full range of statistics and information for 70 or more federal agencies. The Federal Interagency Council on Statistical Policy maintains this site to provide easy access statistics and information produced by these agencies.

Preventive Health Care Application – Key Questions

- The effective use of the PHCA requires two components:

  1. Integration of data from the HEAR 2.0 CHCS, and the Immunization Tracking System.
  2. Alteration of clinical business practices to implement PPIP.

  - Which of the PHCA components is in place in your organization?
  - How well is each working? What needs to be done to improve function?
  - Is there command support for health promotion and wellness programs and activities?
  - Is there a health promotion center (HPC) in operation? Is so, how are referrals made?
  - Who is authorized to refer health care beneficiaries? Who teaches the classes?
  - How does your clinic interface with the HPC, if at all?

  NOTE: A good POC may be your CHN or Preventive Medicine Service.

- **MEDICAL SURVEILLANCE**

Disease and non-battle injury (DNBI) rates are the "vital signs" of a unit. Deployed troops generally operate distant to a medical center and encounter a variety of minor complaints, which in aggregate, may be early signs of a natural epidemic or biological/chemical attack. It is essential to differentiate normal from abnormal disease rates at the unit level so that problem areas can be quickly identified. Fast identification allows rapid mobilization of appropriate medical resources for early interventions.

- Do you know the population your clinic serves, to include active duty personnel, supported military units, health care beneficiary civilians, and occupational health beneficiaries?
- Do you know the basic number of DNBI problems managed by your clinic?
- Have you used your PAD and G1/S1 personnel to assist in obtaining information about the units served by your clinic, the number of troops in each clinic, the number of civilian health care beneficiaries, and the number of workers served by occupational health? This serves as "denominator" information for rate calculations.
- Have you collaborated with the CHN in developing surveillance of problems covered by the clinic, and aggregation of that data? This provides the "numerator" for rate calculations.

SECTION III. PATIENT FOCUSED FUNCTIONS

The following paragraphs provide a brief introduction to other nursing challenges in the ambulatory environment. The AAACN standards provide excellent specific guidance for each of these patient related requirements.

❑ Focused Assessment and Documentation

For the outpatient, the processes of assessment, intervention, and documentation tend to be brief and problem focused. A fifteen- or twenty-minute encounter allows little time for in-depth consideration of the myriad of coexistent patient needs or extensive, elaborate documentation. With attention to the history and health promotion/disease prevention needs of the HCB, the assessment and related intervention and documentation must be directed to the issue or the chief complaint that brought the patient to the facility for that visit. Given the time constraints in the ambulatory setting, the challenge to the interdisciplinary health care team is to be sensitive to the holistic needs of the client and proactive in addressing these needs. Scheduled follow-on appointments, telephone follow-up, and referrals between professional disciplines, to include the case manager, are appropriate ways to effectively serve the HCB.

❑ Patient Education

"The goal of patient and family education is to improve patient health outcomes by promoting healthy behavior and involving the patient and, as appropriate, the patient's family in care and care decisions." (From AAACN standards)

Health promotion, disease prevention, and effective disease management require professional nursing intervention. The nurse is the coordinator of the interdisciplinary information and instruction with the specific goal of increasing the HCB's knowledge. These educational responsibilities may include: the development of comprehensive, concise, teaching plans for use with selected patients; the management of referrals from the privileged provider to the nurse for focused patient education; community-based/group educational programs; feedback loops for referrals made to services outside the facility; and the establishment of liaison roles with the military and civilian communities. Many clients in the ambulatory setting derive tremendous benefit from the one-on-one or group educational activities planned and presented by the professional nurse. Establishing/implementing a process to identify and direct patients to the RN for these services is essential. Through both formal educational programs planned by the RN and "just in time" patient teaching in a variety of settings, the educational needs of the HCB can be effectively addressed.

❑ Patient Rights and Organizational Ethics

Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. These values often influence the patient's perception of care and illness. Understanding and

respecting these values guide the provider in meeting patients' care needs and preferences.

- How efficient and customer-friendly is your reception desk staff?
- Are there problems that may effect the positive clerk/customer interface?
- Are there “patient rights and responsibility” signs clearly visible in the patient areas?
- Is the clinic arranged to provide patients confidentiality, visual, and auditory privacy without compromising patient care? To include front desk, screening/triage area, and treatment/exam areas?
- What patient education materials are being used? Is this information standardized across the organization? How are these materials ordered/obtained?

Continuum of Care

Over time, patients may receive a range of care in multiple settings from multiple providers. For this reason it is important for a clinic to view the patient care it provides as part of an integrated system of settings, services, health care practitioners, and care levels that make up a continuum of care.

- Is continuity of care an issue in your organization? Your clinic?
- How is the issue addressed?
- What is the role of the Primary Care Manager (PCM)? Is the concept working?
- How are the care results of an Emergency visit or other episodic care received by the patient communicated to the PCM?
- Does the PCM receive a copy of the inpatient discharge summary for his patients?
- Is access to medical records, particularly after hours provided/available?
- Is there a mechanism in place to promptly notify patients of lab/x-ray/consult or referral results? What is the policy? Is policy for all results or only abnormal results?
- What is the standard for specialty care referrals, surgery?
- Are consults scheduled within established access standards time limits? What percent of consults generated are “lost” in your system?
- How are consult results tracked to ensure providers receive these data?
- Is feedback from consults readily available? If not, what improvements can be done?
- Are the CHCS and the Ambulatory Data System (ADS) used effectively to access patient clinical data?
- What reports are available and how is data used?

SECTION IV. ORGANIZATION FOCUSED FUNCTIONS

❑ Access to Care

The ratio of primary care manager to beneficiary has been discussed in health care forums since the advent of managed care. Until recently, military treatment facilities used different primary care ratios to plan to meet TRICARE access standards. The Office of the Assistant Secretary of Defense for Health Affairs published the MHS primary care enrollment model in January 2000 to provide a guide for facilities to predict their capacity to provide primary care, standardize enrollment projections for resource allocation, and provide data to be used as a basis for managed care support bids. The goal of the model is to enable facilities to *1) predict the portion of the catchment area population that can be effectively enrolled; 2) identify factors which could be improved to increase enrollment capacity; 3) receive financial resources commensurate with enrollment capacity and predicted workload and; 4) monitor performance and improve enrollment capacity.*

Optimizing enrollment capacity for each primary care provider will provide challenges in meeting the TRICARE access standards. It is important to be aware of these issues and other concerns regarding health care delivery both from the perspective of the provider and the HCB. Customer satisfaction surveys and conversations with patients provide valuable feedback related to their attitudes, perceptions, and expectations. Access to care can be enhanced by implementing demand management techniques and patient responsibility when making and canceling appointments, being on time for appointments, and rescheduling appointments when necessary. Success in meeting the TRICARE access standards for urgent, routine, and specialty care requires that an effective partnership be developed between HCBs and all health care staff in addition to appropriately designed appointment templates. Efforts by the organization to educate and inform enrolled HCBs about each of their responsibilities can result in enhanced access and care delivery.

NOTE: For further information on TRICARE access goals and performance measures, review the following web site: http://tricare.osd.mil. Go to the Defense Health Program Management Link; select performance measures section; and go to TRICARE Operational Performance Statement (TOPS) to review your organization's specific access metrics that is based upon results of the DOD customer satisfaction survey (CSS).

❑ Overview

It is important to understand the operation of your organization and how and where you fit. The following information is organized by both Joint Commission patient or organization focused standards and topic/issue as each pertains to the ambulatory setting. Following each topic is a list of questions to direct your thinking and your orientation to the role of providing ambulatory care. The answers to many of the

questions are facility specific. Your challenge is to search out the information that you will need to successfully provide and direct care in your work setting.

Clinic/Unit Management

Management of Human Resources

- What is the system for licensure verification in your organization?
- Who is responsible for clinic personnel?
- Is the license of each of your licensed employees (RN, licensed practical nurse [LPN], volunteers, and contract personnel) current, valid and unrestricted?
- Is there a competency-based orientation that addresses your administrative and management responsibilities in this work setting?
- How current is the Competency Based Orientation (CBO) program for your practice setting?
- Does your competency assessment program include age-specific training?
- Are there changes or enhancements that need to be made to this program?
- What are the skill levels of the 91-series soldiers assigned to your clinic?
- What training is in place to develop the patient care skills of these individuals?
- Are you familiar with the contents of the Nurse Practice Act (RN and LPN) for the state in which your medical treatment facility (MTF) is located? Do you have a copy for reference? (This useful reference is available on the Internet at http://www.ncsbn.org).
- Do all personnel have written job descriptions that are accessible to them? Are they current, i.e., reflect duties of employee?
- For GS-8 and below personnel (base system), are counseling checklists (DA Form 7223-1) available? Was each individual counseled in the first 30 days and at least in the middle of the rating period?
- For GS-9 and above employees, are support forms (DA 7222-1) with objectives available?
- Are performance standards available for civilian employees to review? Are they signed annually?
- Are volunteers working in your clinic? Are their roles congruent with the orientation and training that each received and demonstrated competencies? Is there a hospital policy related to the use of volunteers? Are there job descriptions/duties/limitations?
- Are you familiar with the responsibilities of each of your employees? With specific employee problems or concerns related to clinic operation?
- Do you know what to do in dealing with an employee your suspect is impaired due to a physical or mental disability or who is not competent to provide safe care?
- Do you know how to deal with disciplinary issues--absenteeism, tardiness?
- Is the role of each level of personnel (assigned and volunteer) working in the clinic clearly defined in current job description?

- What certification/credentialling/competency verification of personnel is required and how often? Who is responsible for training?
- Are resource sharing or contract providers providing care in your clinic? How are the services of these contracted employees arranged? Who monitors their work?
- Are there problems with: appointment templates, appointment availability, no shows/cancellations, work flow, staffing (all levels), support to the clinic by ancillary services (laboratory, radiology, patient administration [PAD], pharmacy), patient privacy, confidentiality, telephone or computer support, military/civilian personnel, other?

  NOTE: The DA civilian personnel system, Total Army Performance Evaluation System (TAPES), is explained in DA Pamphlet 690-400.

Use of Unlicensed Assistive Personnel (UAP)

Army nursing has long recognized the contributions of medical specialists' support to the professional nurse in the delivery of safe and effective patient care. It is essential for clinic leaders to know the scope of professional nursing care and what can be appropriately delegated to be performed by the medical specialist and nursing assistant. In determining appropriate task delegation, the RN must consider the patient's needs, the education and training of the UAP, the complexity of the nursing task to be delegated, the stability of the patient, staff workload, and the scope and availability of supervision required. If a licensed practitioner other than the RN delegates tasks to a UAP over whom the RN has supervisory responsibility, the RN is still accountable for verifying the UAP's training and competency to perform that task. In addition, the care they provide must be consistent with regulatory guidance, professional standards of nursing practice, and your organization's policies. Any intervention requiring professional nursing knowledge, judgment, and skill cannot be delegated.

The Army defines medical specialist as: an unlicensed, medically trained military person who administers frontline emergency medical treatment to combat soldiers under the supervision of a physician or physician assistant or assists with inpatient and outpatient care and treatment under the supervision of a physician, nurse, or physician assistant or NCO.

A nursing assistant is an unlicensed civilian who performs a variety of nursing care work involving personal care, diagnostic procedures, treatment, charting, and patient teaching, but which does not require professional nurse education or knowledge and skills represented by licensure. Nursing assistants may or may not be certified.

The ANA defines three key terms that are critical in understanding the relationship of the professional nurse and UAP:

UAP. "A UAP is an individual who is trained to function in a supportive role to the registered professional nurse in the provision of patient/client care activities as delegated by and under the supervision of the registered professional nurse. Other

licensed/privileged personnel may delegate to UAPs within their scopes of practice.

Delegation. Delegation transfers responsibility, but not the accountability, for the performance of a task from one person to another. The RN (or other licensed practitioner) as the delegator is still accountable for the process and outcome. (reference ncsbn website).

Supervisor. Supervision is an active process of directing, guiding, and influencing the outcome of staff performance of an activity or task.

- Are medical specialists or nursing assistants **(**UAPs**)** used in your setting? If so, are the roles and responsibilities of the RN and UAP clearly defined?
- Do RNs delegate and supervise the work of UAPs?
- How are RNs prepared for delegation?
- Is there a written unit or institutional policy that discusses the delegation or use of UAPs?
- Are clear guidelines available to all staff as to which functions can and can not be delegated? Do UAPs perceive the delegated tasks to be fair and realistic workload?

NOTE: An excellent reference for further discussion/guidance on UAPs is the ANA pamphlet*, Registered Professional Nurses and Unlicensed Assistive Personnel* or MEDCOM Circular 40-9, Medical Specialist (91B MOS) and Nursing Assistants (NA).

Management of Environment of Care

- Are all medications, needles, and syringes secured? Who has access and how?
- How are controlled substances secured and accounted for? Who has access?
- Are required warning signs and emergency notification rosters posted?
- Are spill kits available?
- Is equipment in good working order? Do you have the manufacturer's instructions on all equipment in order to perform appropriate maintenance and quality control checks?
- Where are the fire evacuation plans posted? Are escape routes from that location indicated?
- Are fire exits clearly marked and lighted? Free of obstacles both inside and outside?
- How often are fire drills conducted?
- Do personnel know fire procedures? Location and use of fire extinguishers?

Leadership

Leaders provide the framework for planning, directing, coordinating, providing and improving health care services in response to patient needs.

- Are there any personnel problems (excessive use of sick time, grievances, incompetency or tardiness)?
- How are overtime, compensatory time, sick leave and annual leave allocated/scheduled and tracked?
- What special procedures/services/classes are offered in your clinic, i.e., conscious sedation, peripherally inserted central catheter (PICC) line placement, medication counseling, tobacco cessation class?
- Are there policies in place which address the various high risk or problem prone activities referenced above? Who performs these procedures or assists with these procedures? Do all understand the scope of practice of the various levels of staff assigned to the clinic?
- Are Ambulatory Procedure Visits (APVs) performed in your clinic? What policies are in place to address the management of this category of patient? Have there been any issues related to APVs? Workload accounting?
- Is observation care provided in your clinic? Are your patients referred to another area of the MTF for this care? How well is this process working? How is workload accounted?
- What are the documentation requirements for routine clinic visits, invasive procedures with or without conscious sedation, APVs, and observation care?
- How were staffing levels for your clinic determined? Are the staff numbers/mix adequate? How do you obtain additional manpower on a short-term basis?

Management of Information

Information is obtained, managed and used to improve patient outcomes and individual and organization performance. Delivering health care is a complex process that is highly dependent on information.

How is workload measured in your work center? Is there a methodology in place to determine the acuity and staffing needs of the HCB's need for care? Have local staffing standards been established? By whom? Are the expectations realistic?

- Is workload reported in Medical Expense and Performance Reporting System (MEPRS)? Has a treatment area, Ambulatory Procedure Unit or observation center been established in your clinic? How is workload accounted?
- What is ADS? What are nursing personnel responsibilities for ADS? Do nursing staff complete the forms?
- What is the relationship between ADS and MEPRS? With third party billing?
- Who is involved in workload data analysis? How is feedback related to the workload data made available to clinic management staff and providers?
- How is data used to make decisions regarding clinic operation and care delivery?

Telephone Advice/Triage

- What telephone services (advice, triage, health care information line (HCIL)) are in place for use by your HCBs? How is each of these terms defined by your organization?
- Are there policies (organization, unit) in place that address these services? Are the priorities consistent with TRICARE?
- Who provides these services? If provided by an employee of your organization (noncontract), does the job description enumerate the responsibilities specific to telephone services?
- Are there physician-approved guidelines in place to support the services being provided?
- Who has oversight of the telephone services offered? How are problems handled?
- What training has the telephone services staff received? How has each individual's competence to perform these services been assessed/reassessed?
- What quality management processes are in place in support of the telephone services offered?
- What documentation is generated to substantiate the telephone interaction between care provider and HCB?
- How is patient satisfaction with telephone services determined?
- How is workload tracked to determine staffing needs and to monitor patient waiting/queuing times?
- If call volume is low, what other duties are performed by the telephone staff?
- Have you used the telephone services to acquaint yourself with the triage/advice services available to your health care beneficiaries?
- Are they documented in CHCS and ADS?

NOTE: An excellent reference for further discussion/guidance on telephone services is the AAACN pamphlet, *Telephone Nursing Administration and Practice Standards.*

Emergency Services

- What level of Emergency Medical Services (EMS) is available at your facility?
- What interaction takes place between your MTF and community EMS?
- What is your MTF's policy on treating civilian emergencies?
- What is your MTF's policy for evaluating/treating HCBs in your Emergency Department/Center (ED/EC)?
- How do patients receive follow-on care after treatment in your ED/EC
- How do you initiate code blue procedures?

Other Clinics

- What are the common issues between clinics?

- To whom have these issues been addressed? Is resolution forthcoming?
- What patient education materials are being used? Is this information standardized across the organization? How are these materials ordered/obtained?

Joint Commission on Accreditation of Healthcare Organization (JCAHO)

- What are the patient-focused standards of the JCAHO? The organization-focused standards?
- What are the primary Type I findings for ambulatory services from recent JCAHO surveys?
- Is there an ongoing interdisciplinary performance improvement program that objectively and systematically monitors and evaluates the quality and appropriateness of patient care, improves opportunities to improve patient care, and resolves identified problems?
- What were the most recent JCAHO results (organization and unit specific)?
- Do you have a copy of the most recent Joint Commission Survey Accreditation Report?
- Are there issues related to the JCAHO that warrant immediate attention?
- What is your scope of services (organization and unit specific)?
- Is your clinic an ambulatory setting in which nursing care is delivered as defined by your organization's scope of services?
- What are the implications related to both practice and documentation of care provided?

NOTE: For a POC to answer questions related to JCAHO or to discuss your issues, contact your facility/nursing quality management office or the staff of the Quality Management Office, USAMEDCOM at (210) 221-6195/8938 or DSN 471-6195/8938.

Marketing the Role

It is essential for professional nurses to recognize and articulate the contributions he/she makes to patient care services in the ambulatory care practice setting. Marketing the value of the professional nurse role to each other, to organizational leadership, to one's colleagues, and to the public is critical.

- Are you able to effectively justify the need for a professional registered nurse (RN) in your work center vs. a licensed practical nurse (LPN) or nursing assistant (NA)?
- Are the duties of the RN, the LPN, and the NA noticeably different but complimentary?
- How do you document services and outcomes?

DIRECTIONS TO THE READER:

The remainder of this self-directed orientation guide is devoted to structure and function within your organization. The intent is to encourage you to take a comprehensive and detailed look at the health care system of your MTF. There is no particular order in which the material provided should be reviewed. A reasonable starting point might be to examine the subject headings and identify those issues or areas that merit immediate attention based on your particular work setting. Regardless of where you work or the issues in your area of responsibility, knowing the system in which you work and the people who are key players is critical to your success. As in the previous section of this primer, the topic with questions following format is used.

SECTION V. ORGANIZATIONAL RELATIONS

❑ THE MISSION

General

- What is your organization's mission? Is there a written mission statement, which includes the Commander's vision for the organization? Are nursing and the provision of nursing care addressed in the mission statement for your organization?
- Where does ambulatory care fit in?
- With what other departments/divisions will you need to interact to be most effective in your job?

Executive Leadership

- What are the expectations of you from those in leadership positions in your organization?
- What is the chain of authority in your department/service and where do you fit?
- What are the organizational goals specific to the ambulatory setting? To your clinic?
- How do you view your role as a professional nurse in the ambulatory setting?
- How is that role perceived by other staff members--supervisors, colleagues, and subordinates? If you are not sure, ask.

❑ KEY OPERATIONS/FUNCTIONS WITHIN THE ORGANIZATION

Multidisciplinary Collaboration

Professional collaboration among all disciplines is key to a successful organization. Knowing the vision, mission, and core processes of an organization are critical elements in providing a quality product in this business of health care delivery. Being cognizant of each team member's function and role in this complex interdependent network fosters the communication and cooperation required to accomplish the mission. Be creative, take **calculated** risks, and seek advice from supervisors, colleagues, and subordinates. Aim for a customer-focused and friendly environment!

Organizational Structure

- Is there an organizational wire diagram or roster of departments/key personnel?
- Where is each department/service/section located within the organization?
- What is the function/role of the department/service/section?
- Who is the POC? Where are the telephone and fax numbers?
- What do you need to know about each department/service/section to do your job effectively?

Resource Management Division (RMD)

- What are the various sections within RMD? What does each do? Who is the POC if there are problems?
- What are the budget related issues for the organization/your clinic?
- Is there a separate budget for your clinic/work setting?
- What are your responsibilities related to management of the clinic's budget?
- What data sources are utilized by RMD for decision making?
- Are there recurring reports which must be submitted by your clinic?
- What personnel manning documents are in use (Table of Distribution and Allowances [TDA], mobilization TDA, Table of Organization and Equipment [TOE]? Are they the most current documents? What are the authorizations for your work center? The requirements? How are these numbers determined?
- What is the process for replacing personnel losses (AD military, civilian)?
- What type of personnel contracts, if any are in use?
- How are they managed and by whom?
- How is workload and readiness documented?

Management of Information

Patient Administrative Division

Medical Records

- Where are they maintained? How are they tracked?
- Are there problems with medical record management in your clinic?
- Do all medical records have master problem lists?
- What is your role in medical record review for your Performance Improvement (PI) Program?
- Who are the medical record coders? Where are they located? Who provides oversight to ensure that medical records coding is accurate, to maximize medical insurance reimbursement (Third Party Collection)?
- How do the medical records coding, the ADS, and Ambulatory Procedure Visit (APV) processes relate?
- Where are the results of PPIP?
-

Patient Appointment System (PAS)

- Is your PAS centralized or clinic based?
- How is this service staffed?
- What are the hours of operation and phone numbers?
- Is there a backlog? If so, why? Who (What HCBs) comprises the backlog? What is being done to reduce/eliminate any appointment backlogs?
- Is the clinic in compliance with access standards?
- Are patients being appropriately referred for care?

- What are your “no-show” and cancellation rates? And phone appointment stats?
- Who are these “no-shows,” i.e., who fail to keep/cancel their scheduled appointments? What are the reasons? Is there a follow-up plan for “no-shows” in place? What is the clinic/MTF policy?
- What percentage of available appointments is for TRICARE Prime HCBs? For other HCBs on a space available basis?
- Who books what type(s) of patients (MTF versus managed care contractor)?
- Does the TRICARE contractor make appointments? If so, who is your liaison for any problems?
- What is the procedure for booking space available patients?

Third Party Collection Program (TPCP)

- What is the source of TPCP revenues? What impact does TRICARE have on TPCP revenues?
- How is information provided to the Third Party Collection Office for claims processing? Have there been problems?
- What codes are applicable to your work setting? How can the TPCP be maximized? Who codes for the clinic?
- How is the TPCP money allocated? Are there restrictions for use of these dollars, by the MTF or clinic?
- Do all or a portion of these dollars return to the clinic? How is it used or distributed?
- What is the responsibility of nursing personnel related to the TPCP?

Information Management Division (IMD)

- How is equipment procured?
- What is the source of financing for equipment?
- What service contracts exist for the equipment in use?
- Who funds the service contract expense once the initial contract expires?
- What future systems are planned?
- Is there an IMD help line? If so, what is the telephone/pager number?
- What equipment is currently available in the hospital/clinic? How old is it?
- What is the process for getting upgrades?
- What are the capabilities of the existing equipment? Who knows the equipment well enough to provide orientation/training on its use?
- Do the various systems in place “talk” to one another?
- What training programs are available for the existing information management systems?
- Do you have automated patient records? If so, what is the process to ensure patient confidentiality and security?

Patient Representative (PR)

- What is the role of the patient representative in your organization?
- Are there any significant patient represntative issues, for the organization/your clinic?
- Are there any trends in patient complaints?
- What are your customers' expectations related to your clinic?
- Are there any customer satisfaction issues? How are these evaluated and incorporated into the PI program?
- How do the PR issues/information get back to clinic staff?
- What training opportunities are offered to staff on customer relations?

Pubic Affairs Office (PAO)

- What is the role of the PAO? Where is the PAO located?
- What publications are prepared/distributed by your PAO?
- Is there a patient information handbook that describes services offered?
- What is the policy on queries for information from outside the organization? Patient queries?
- What are the options for dissemination of patient education information or advertisements for health care services?
- How aggressive is the marketing of TRICARE Prime?
- Who is responsible for these marketing efforts?

Contract Officer Representative (COR)

- What is your level of interaction with this individual?
- How many contracts are in effect? With whom?
- How is time worked accounted for contracted employees? Who is responsible? What are the rules for overtime, compensatory time, and holiday time?
- What information is available regarding contracted services/employees?
- What is your responsibility for directing and supervising work performed by contract personnel?

Logistics

- What is your MTF's policy regarding commercial sales representatives? Who is responsible for authorizing them to be in the MTF/clinic? How is approval known (i.e., badge)?
- What is the definition of a prime vendor? Is this program in place in your organization? What are your responsibilities related to this program?
- Supply acquisitions, what about :
  - Special order supplies?
  - Sole source purchase requests?
  - Reports generated by logistics for your clinic?

- What is the life expectancy of the equipment? Where are these records kept?
- What is the procedure for purchase of new equipment?
- How is high dollar Capital Expense Equipment Purchasing (CEEP) accomplished? Are there instructions for preparing medical care support equipment (MEDCASE) requests?
- What do you need to know related to scheduled maintenance of equipment, equipment repair?
- Who is responsible for checking maintenance tags?
- What are the guidelines/restrictions in place governing the use of government credit cards for supply purchases? Who in the clinic is authorized use of the card?
- Are there any specific safety issues or physical plant problems in your clinic?

Headquarters Company

- What is the level of interaction between the company commander or company personnel and your clinic staff, to include you?
- When are duty rosters posted? How are changes made to the roster if you have staffing issues?
- What is the procedure to document disciplinary problems?
- What disciplinary support is available through the company?
- What company requirements must be taken into consideration when planning clinic coverage?
- Identify the channels of communication with and through the company.

S-1/G-1 Personnel

- How many clinic personnel are Forces Command (FORSCOM) assets? Professional Filler System (PROFIS) assigned?
- What is the military rating scheme for your work unit? Is it posted?
- What military personnel do you supervise and rate?
- When are the military (officer, enlisted) evaluation reports due? Who is available to provide assistance in preparing these reports?
- Have there been problems with submission of these reports (lateness,
- quality)?
- What is the procedure for military temporary duty (TDY)? Tuition assistance?
- What is the process for submitting military awards (DA 638) Is AR 600-8-22 available for reference in writing awards?
- What is the unit manning report (UMR)? Who maintains this report?
- What are the role of the clinic Noncommissoned Officer In Charge (NCOIC) and the section/department NCOIC?

S3/G-3 Operations

- What impact does FORSCOM/PROFIS training have on your organization/clinic?

- What ongoing/periodic readiness training activities are required? Are any of these training activities conducted within the clinic? What is the clinic routine during this training?
- Who coordinates any assigned tasking and training?
- What is the clinic routine during this training?
- How are tasking and training requirements communicated to clinic administrative staff? To the soldier? How are arrangements for replacement personnel made?
- What are the military training demands on military duties that will affect clinic operations and assigned staff (Army Physical Fitness Test [APFT], enhanced physical training [PT], common task training [CTT], officer professional development [OPD], noncommissioned officer professional development [NCOPD], Sergeant's Time, company formations)?
- When does training take place and how long does it last?
- Who publishes the organization's training schedule? Do you get copies?
- What are the mandatory military and hospital training requirements?

Civilian Personnel Advisory Center (CPAC)

- Does your post offer the Leadership, Evaluation, and Development (LEAD) Course?
- Have you had the Total Army Personnel Evaluation System (TAPES DA Pamphlet 690-400) training?
- What is the procedure for enrolling in correspondence and on-site training?
- Have you completed the 40-hour civilian personnel supervisory course? Are there any staffing actions at CPAC?
- What is the role of Management Employee Relations (MER)? Who is your MER representative?
- What is the role of the union?
- Are there union-negotiated agreements in place? Do you have a copy for reference?
- What are the procedures for hiring or firing an employee?
- What is the civilian rating scheme for your work unit? Is it posted?
- What civilian personnel do you supervise and rate?
- What are the procedures to be followed in handling a grievance? For civilian training or TDY? For developing civilian performance plans? For civilian performance appraisals? For civilian awards?
- When are civilian performance counseling and appraisals due? Who is available to provide assistance with counseling issues or in preparing the appraisals?
- Who is the civilian timekeeper in your clinic?
- What is the proper procedure for time card completion and submission?
- If you have an electronic system, who has authorization to use it?

Formal Education Activities

- Is there Graduate Medical Education (GME) or other student training underway in the clinic? How does this effect clinic operations?
- Does your clinic participate in other military training on a periodic basis, .e.g., MOS Proficiency Training (MPT) or Long Term Health Education and Training (LTHET) students, Special Forces medic (18D) or United States Army Reserve (USAR) training?
- What civilian health occupation training programs does the clinic support, .e.g., Certified Nursing Assistant (CNA), LPN, RN, NP students?
- Who are the POCs for these programs? Are copies of the MOU between your MTF and the civilian institution on file in the clinic? What are the responsibilities of the clinic staff for student activities/supervision? What are the procedures for resolving student issues or problems?

Department Health Care Administrator (HCA)

- Does this role exist in your organization/clinic?
- What are the duties and responsibilities of the HCA?
- Who is rated by this individual?
- How do your roles and responsibilities differ?

Community Health Nursing/Preventive Medicine (CHN/PM)

- What are the responsibilities of CHN/PM in your organization?
- What CHN/PN initiatives require support in your clinic?
- What patients are to be referred to CHN/PM for service? How are they referred?
- What gaps in service exist that require new initiatives?
- Are there any significant CHN/PM issues in your military community?
- Is home care being provided for enrolled beneficiaries? By whom?
- What is your role in assisting civilian agencies with required home care for enrolled HCBs?

❑ EXTERNAL ENVIRONMENT

Civilian Community

- Who are your Health Benefits Advisors?
- Who are the available providers in your network? Who are your partners in care?
- Are civilian providers utilized for health care services? If so, for what services?
- What community agencies are involved in providing care to MHS HCBs served by your MTF?
- What inter-organizational interaction takes place?
- What impact, if any, does this have on your work center?

- What issues exist as a result of direct involvement with the civilian community providers and agencies? To whom are these issues referred for resolution?
- How are requests for assistance from civilian sources (educational classes, health fairs, etc.) handled?

Disaster Planning

- Is there a written organizational and community Emergency Preparedness Plan (EPP)? Is your work center directly involved in the EPP? What roles does your clinic play? What is your assigned role? Do all support staff know their roles? Is a copy of the EPP available to you? What is the mechanism for providing input?
- What community agencies/services participate in the EPP for your organization?
- Are joint mass casualty (MASCAL) exercises planned and executed? How often?
- What is the source of feedback regarding these joint endeavors?
- Are After Action Reports (AAR) available for review?
- What problems or issues were identified in the most recent training exercise? Were these addressed and resolved?
- Is your alert roster current? Do all clinic personnel have a copy? Has it been tested? What are the responsibilities for calling and reporting when initiated?

Military Community (Post)

- What is the Chain of Command from MTF through post headquarters?
- Who are the senior military personnel on post?
- What relationship exists between garrison units and the MTF?
- What soldier health care issues are of concern to this leadership group?
- What are the expectations by post leadership of the medical service support?
- To date, how effective has the MTF been in meeting these expectations?
- How are health related issues and expectations surfaced?

SECTION VI. MANAGED CARE ISSUES (TRICARE)

Managed Care

- What is the chain of communication for raising managed care related issues?
- Where is the managed care terminology defined or explained?
- What are the TRICARE options and where are they explained?
- Are beneficiary enrollment packets available? Obtain one to review.
- What does managed care mean to your organization?
- What is your facility's model for primary care?
- How are the specialty services accessed within your facility? Those outside your facility (military or civilian)?

  NOTE: To access further information about TRICARE, select the following web site: www.armymedicine.army.mil and click on TRICARE at the top of the page or select www.tricare.osd.mil.

Contracts

- What must I know about the Managed Care Support Contract?
- Where do I go, and to whom, with questions or issues concerning the contract?
- What are the contract requirements?
- Who is responsible for ensuring that staff understand the contract requirements?
- What are the responsibilities of contractor personnel?
- What are your responsibilities?
- What action should be taken when the contractor is not performing according to the contract requirements? Who is the POC (first line) for problem resolution?
- What are "out of benefit" services? Who negotiates for these services? Who is the POC?
- What is a point of service option? How and when is this option exercised? How can it be prevented in the ambulatory (referral management) setting?

Contracting Officer Technical Report (COTR)

- Who is the Contracting Officer Technical Representative (COTR) for the organization/your department? What are the COTR's responsibilities?

Resource Sharing vs. Resource Support

- What is the difference between these terms? Is there a negative vs. positive impact to the organization related to either type initiative? When are each appropriate?
- Is either of these resource conservation initiatives in place in your organization? With whom?
- What benefit is derived from these arrangements?
- Is resource sharing appropriate for other settings in the organization?
- How is a Resource Sharing or Support agreement initiated?

Enrollment Based Capitation (EBC)

- How does this affect the organization/your clinic?
- How many eligible enrollees vs. actual enrollees are in your catchment area?
- What is the effect on workload and budget?
- What are the catchment area boundaries? What zip codes are in your catchment area?
- What issues are currently affecting enrollment?
- What are the future implications?
- What is the organization's patient population?
- Over the past three years, has workload (MTF/clinic) gone up or down or stayed the same? Why?
- Has the case mix index changed?
- How does your workload compare with other comparable size and service clinics in your organization? In your region?
- Are non-MTF enrollees being referred to your MTF? What is the impact on your organization?

Referral Guidelines

- What are the access standards for your organization under the Department of Defense (Health Affairs) managed care support contract? What referral guidelines are in use at your facility? In your clinic?
- What patients/services are being referred out of the system? Why?
- What are the out-of-pocket costs to the patient?
- What are the system issues? How are clients managed who are referred from outside your catchment area?
- Which of the network providers are high use for your area of responsibility?
- Are CHCS electronic referrals used?
- Is feedback related to referrals to another provider readily available? If not, why?
- What is a care authorization document? Why, how, and where is one obtained?
- For non-Prime enrollees in your catchment area, how much demand is there for non-availability statements (NAS) issued by your MTF? How many were issued last fiscal year? For what services?
- How is pre-authorization for specialty care obtained?
- What criteria are used for prospective review? Who does this?
- What is the turn around time for consults per contract requirements?
- What are the contract requirements for TRICARE Prime, Extra, Standard (direct care vs. purchased care vs. network and non-network care)?

Health Benefits Advisor (HBA) Or Beneficiary Counseling and Assistance Coordinator (BCAC)

- Who is this individual and where is he/she located?
- What are the responsibilities of the role?
- When should patients or clinic staff contact the HBS)?

TRICARE Service Center (TSC)

- Where is the TSC located?
- Who is the POC? Hours of operation and phone number **(**varies with region)?
- What services does the TSC offer, and to whom?
- Are enrollment and requests to change enrollment forms available in the clinic/MTF?
- How are your customers educated about TRICARE and about the TSC?
- Is the clinic staff well informed about the TSC, and the services available to your HCBs?
- How does the HCB enroll in TRICARE? How does the HCB request a change of primary care manager (PCM)?
- What is the Health Care Information Line (HCIL)? What services are provided?
- How are patients informed of this service?
- What information is available/reported reference your enrollees use of the service and their disposition?

Health Care Finders (HCFs)

- What are the demographics of the patient population your organization/clinic serves?
- How are they enrolled?
- What are the most common referral requests?
- How well satisfied are your HCBs with the services of the HCF?
- What clinical referral guidelines have been established? Does your clinic have copies?
- What is the TRICARE Regional Appointment Center (TRAC)? What services are offered? How does the HCF integrate or interface with the TRAC?
- What MTFs (military/civilian) are involved in the referral of patients for care outside your organization?
- Are the HCFs employees of the MTF or the contractor?
- What requirements must be met before the HCF services may be utilized?

Medicare Demonstration Project/TRICARE Senior Program

- What is this program?
- Does your organization participate in this program?
- What are the eligibility requirements?
- What are the benefits to the participating organization?
- What are the financial ramifications of this program on your clinic/MTF?

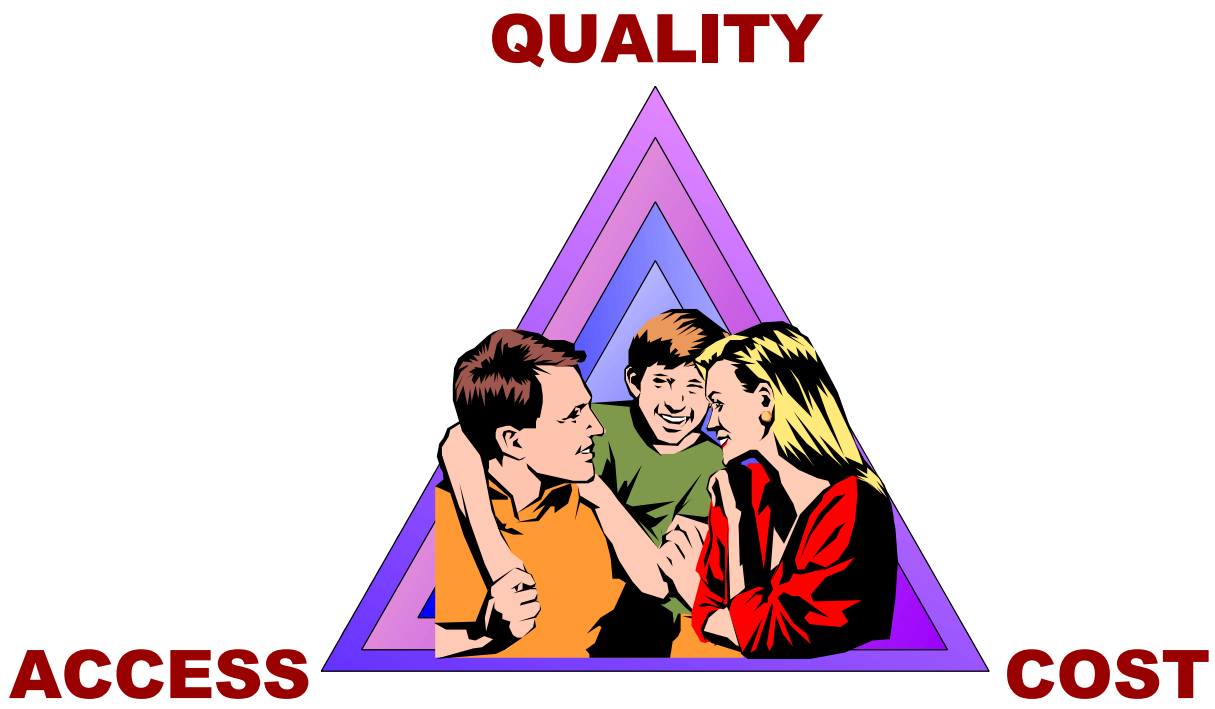
- What Health Care Financing Administration (HCFA) requirements apply as a result of implementation of the TRICARE Senior Program? Where are these requirements referenced?
- What does the TRICARE Senior Program benefit offer the eligible HCB?

NOTE: Other demonstration projects for beneficiaries over 65 are Pharmacy Expansion, Senior Supplemental demonstration, and the Federal Employee Health Benefits Plan-M.

TRICARE Prime Remote

- What is this initiative all about?
- Who is involved in this program?
- Does this have any impact on your organization?

NOTE: Good web sites for this program are http://www.tricare.osd.mil/remote and http://navymedicine.med.navy.mil/mmso. Active duty service members (ADSM) stationed overseas should call overseas Lead Agent to inquire about health care options available in their country. The ADSM can call 1-888-777-8343 for information.



SECTION VII. UTILIZATION MANAGEMENT (UM)/ OUTCOMES MANAGEMENT (OM)

- What are your top 25 high-cost, high-volume inpatient, outpatient and Same Day Surgery (SDS) visits and procedures for your hospital? For your clinic?
- What prevention or population health initiatives does your MTF/clinic have that focus on these high-cost, high volume visits and procedures?
- How does your MTF's cost, quality, access (time to appointment) and customer satisfaction performance on its top 25 high cost, high volume conditions compare with other DOD MTF or civilian healthcare organization performance on these conditions? How does your work center compare?
- What prevention initiatives are targeted at your MTF's high cost, high volume conditions?
- What condition management initiatives are targeted at your MTF's high-cost, high volume conditions?
- Does your MTF utilize **clinical practice guidelines (CPGs)** to manage its high cost, high, volume conditions?
- Does your MTF utilize **case management** to manage its high cost, high volume conditions?
- Does your MTF utilize **utilization review** to monitor and manage its high cost, high volume conditions?
- Does your MTF utilize **demand management** activities (advice lines, clinical pathways, discharge planning) other than clinical practice guidelines and case management to manage its high cost, high volume conditions?
- Peri-natal health, psychiatric and musculoskeletal injuries are often the high-cost, high volume conditions at MTFs. What prevention and condition management initiatives are directed toward these conditions? Who is the point of contact for each?
- Utilization management should focus first on prevention, condition management and then focus on case management and utilization review activities or additional demand management activities. What case management is available at your MTF?
- What inpatient and outpatient Diagnosis Related Groups and procedures does your MTF conduct utilization review on?
- What demand management activities targeted toward the high cost, high volume conditions does your MTF have in place?
- Condition management, prevention and all other utilization management activities are also performance improvement activities.
- Is your MTF integrating condition management and population health prevention initiatives into its performance improvement plan?
- Are your utilization management activities multi-disciplinary?
- Is your MTF meeting the JCAHO standards regarding utilization management, practice guidelines and disease/condition management?

- **UM/OM: CONDITION MANAGEMENT AND PREVENTION CLINICAL PRACTICE GUIDELINES**

- Are you aware of the DOD/VA Clinical Practice Guidelines (CPGs)? Which ones apply to your clinic population? Are they available and in use?
- Are you aware of the AMEDD's DOD/VA Clinical Practice Guideline tool kits? And that the tool kits contain:
  - ❖ Provider documentation forms, continuing medical education videos and provider reminder cards?
  - ❖ Patient disease action plans, education brochures and videos?
  - ❖ Pharmacy and other ancillary service presentations and information.
- Are you aware that the DOD/VA CPGs and tool kits are available from the MEDCOM Quality Management website, http://www.cs.amedd.army.mil/gmo?
- Did you know that feedback and best practices from providers and clinics is incorporated into future versions of each tool kit?
- Are you aware that the Quality Management website links to other professional and federal guideline resource sites?
- Are you aware that the Quality Management, Clinical Practice Guideline Group will provide a tool kit to each MTF and its geographically separated outlying clinics as well as additional patient educational brochures and videos at no cost to the MTF?
- Did you know that the DoD/VA Clinical Practice Guidelines are being phased in system-wide throughout the Army Medical Department?

Guideline Implementation Dates

- Projected DOD/VA Clinical Practice Guideline implementation dates are:
  - Low Back Pain Feb 00
  - Asthma Sept 00
  - Diabetes Jan 01
  - Depression Sept 01
  - Cardiovascular Jan 02
    (Cardiovascular = Hyperlipidemia, Hypertension, Ischemic Heart Disease)
  - Tobacco Use Cessation Jan 01
- Has your MTF implemented these guidelines?

Guideline Implementation Process

Guideline implementation is a systematic performance improvement process. Does your MTF use the systematic guideline implementation process described below?

1. Assessment of extent of condition targeted by the guideline within your population.

   a. Is the condition of sufficient magnitude to develop an MTF-wide implementation plan?

b. If the condition is not of sufficient magnitude to warrant an MTF-wide implementation, how will the MTF ensure that patients with the condition are assured quality of care?

2. Designation of both clinical (physician) and administrative guideline champions

3. Designation of a multi-disciplinary clinical practice guideline Performance Improvement Team (PIT)

4. Provision of time for the guideline PIT to develop an action plan.

5. Does the developed plan include :
   a. Provider and ancillary education?
   b. Clinical Process Re-Engineering?
   c. Small-scale piloting of guideline implementation
   d. Measurement and feedback of target metrics to the PIT?

6. Institutionalization of guidelines:
   a. Is education regarding MTF guideline initiatives integrated into MTF Newcomer and Birth Month education?
   b. Are the MTF's guidelines integrated into the MTF provider credentialing processes?
   c. Are the MTF's guidelines integrated into its Quality and Utilization Management Committee agendas?
   d. Is the MTF taking credit for the guidelines as performance improvement activities?

- What is your role in this process?

NOTE: For information on clinical practice guidelines http://www.cs.amedd.army.mil/qmo.

- **UM/OM: UTILIZATION REVIEW**

Utilization review (UR) should be focused and done only if there have been Length of stay (LOS), volume or cost outliers for certain DRGs or procedures. For those DRGs or procedures which will benefit from UR:

- What type of utilization review is your MTF performing? Prospective? Concurrent? Retrospective?
- What are the Milliman and Robertson or Health Management Strategies (HMS) (mental health) UM criteria in use in your organization?
- What are these criteria sets? How are they used?
- Who applies the criteria and to which patient populations?

- What UR processes are in place in your organization? What review mechanisms have been established? Who is responsible for what (1st and 2nd review, reconsideration, denial, appeal process)?
- Who maintains the database? What decisions are made based on the data collected?
- What are the quality performance indicators identified by the contractor? Who are they reported to?
- Who is responsible for pre-authorization or medical necessity screening for out-of-catchment area referrals?
- Who receives the UR feedback?
- Is feedback available to you, should you request it? How is it obtained?
- How can you make a difference in the utilization review process?
- What procedures/requests for medical service relevant to your HCBs are not covered under TRICARE?

❑ UM/OM: DEMAND MANAGEMENT

Demand management includes all activities that will decrease inappropriate and increase appropriate utilization of healthcare resources. Demand management activities include prevention and health promotion activities, practice guidelines condition management programs, referral guidelines, phone advice lines, triage, case management and self-help programs.

- What demand management activities are in place at your MTF?
- What are the goals for demand management by your organization? Your clinic?
- Is *Use of Taking Care of Yourself* (or other book) reinforced?

❑ UM/OM: CASE MANAGEMENT

- What conditions are case managed in your population?
- Who are the case managers?
- How do you or your patients contact a case manager?
- How is case management addressed in the Managed Care Support Contract?
- What processes are in place between the contractor and you for Case Management activities? What is your role related to Case Management? What patients/groups are being case managed by your organization?
- How does UR data impact case management activities performed by your organization/clinic?

❑ UM/OM: CLINICAL PATHWAYS

Clinical pathways are a method to improve a health care process' efficiency. Historically, clinical pathways were utilized to decrease long length of stays (LOS) in an effort to decrease the number of occupied bed days (OBDs) and decrease costs associated with over utilization. Today most Army MTFs have no problems with LOS or

OBDs. However, clinical pathways can also be used to effect clinical practice guideline implementation.

- Does your MTF have any DRGs, which exceed the normative DRG LOS? Which ones?
- If so, are clinical paths used by your organization in an effort to decrease the LOS?

❑ **UM/OM: DISCHARGE PLANNING**

- For which high-intensity or chronic conditions does your MTF have focused discharge planning ?
- How effective is the discharge planning for your patient population?
- Are you involved in this process for your high-intensity, chronically ill patients seen in your clinic who require hospital admission?

SECTION VIII. PERFORMANCE IMPROVEMENT (PI)

❑ PROCESS AND OUTCOME PERFORMANCE MEASURES

- Outcomes that are monitored for a given condition include:

  - Morbidity
  - Mortality
  - Length of stay
  - Cost per visit
  - Volume
  - Re-admission rates
  - Emergency Room visits
  - JCAHO ORYX Measures
  - HEDIS Measures
  - TRICARE Operational Performance Statement Measurements
  - DOD/VA Practice Guidelines Metrics

  - Other healthcare organization process and outcome indicators include:
    - Compliance with urgent, routine, specialty and wellness access standards
    - Customer satisfaction
    - Re-enrollment rates
    - Third Party collection
    - Staff competency
    - Ancillary/provider ratio
    - Visits/provider
    - Visits/month
    - Appointment metrics (phone wait, drop offs), no show, cancellations
    - Practice guideline process and outcome indicators

- What performance improvement (PI) model does your organization use to systematically improve existing processes?
- Have all staff members been educated in the organizational PI model?
- What are the process and outcome organizational indicators that are applicable to your clinic? From what sources can you obtain this? How will they be tracked?
- How well did the organization score related to quality on its TRICARE Operational Performance Statement (TOPS)?
- What did the most recent JCAHO survey reveal about the PI activities in place?
- What are your MTF's JCAHO ORYX measures?
- What product-lines do they impact?
- How is your MTF performing on its JCAHO ORYX Measures?
- How are the JCAHO required and ORYX measures reported quarterly at your MTF's Quality Management Committee meetings?
- What process improvements have been instituted relative to your MTF's performance on its JCAHO required and ORYX performance measures?

- Who in your organization receives the congressionally mandated Quality Management Reviews (QMRs) which assess DOD, service, and MTF performance on the quality of maternal-child, cardiovascular, asthma and ambulatory care?
- What performance measures are in place at the organizational level? Clinic level?
- What data are being collected?
- Who in your MTF has access to the JCAHO ORYX website, http://oryxhelp@dynhits.com?
- What improvements have been made to date?
- What PI teams are currently meeting within the organization?
- What is your part in the organizational PI plan?
- What is your overall impression about the quality of service provided by your clinic?
- How are risk management issues handled? To whom are they reported and how?
- How do you identify when a more intensive assessment should be undertaken?

CUSTOMER SATISFACTION

- The DOD has two outpatient Customer Satisfaction Surveys, a monthly Customer Satisfaction Survey of beneficiaries who were successful in attaining appointments within our system and an annual survey of all DOD beneficiaries. The results are reported on a quarterly basis within the TRICARE Operational Performance Statement on the TRICARE website at http://www.tricare.osd.mil. In the monthly Customer Satisfaction Survey satisfaction is assessed at both the clinic and MTF level when sample size is sufficient to report the results. The two major components of customer satisfaction are **customer satisfaction with quality and customer satisfaction with access.** General Shelton, Chairman of the Joint Chiefs of Staff, and other DOD leaders are very concerned that DOD beneficiaries are not as satisfied as they could be. The Army Surgeon General briefs the Army leadership on customer satisfaction with quality and access on a recurring basis.

- How are the results of the survey provided to your clinic?
- How are the results evaluated and by whom? What changes have been made as a result of survey results?
- Does your MTF have a Process Improvement Team to address issues of customer satisfaction?
- At the system-wide level, customer satisfaction with quality has been flat-lined at 86% for the past 2 years. What is your clinic's customer satisfaction with quality?
- What is your clinic's customer satisfaction with access rating?
- Does your MTF have objective customer service plans for each department? Are there consequences for employees who are consistently not customer-focused?
- Does your hospital have a hospitality plan and how is it implemented? What is your role? What are you empowered to do as part of this plan?
- Are employee satisfaction surveys conducted by your organization? How and to whom are the results reported? Have there been any organizational changes as a result of the employee surveys?
  NOTE: For information on customer satisfaction review http://www.cs.amedd.army.mil/qmo.

SECTION VIII. INFORMATION MANAGEMENT

❑ INFORMATION SYSTEMS/SOURCES

- Ambulatory Data System (ADS) - Provides ambulatory data as a by-product of the health care delivery process. Captures patient-specific encounter, diagnosis, and treatment data.
  - Hotline for coding problem/questions: (210) 916-8920/21 or DSN: 429-8920/21.

- Automated Staffing Assessment Model (ASAM) - Provides minimal essential manpower requirements, by medical specialty and service, based on historical workload and medical planning factors.

- Composite Health Care System (CHCS) - A worldwide automated medical information support system. Provides a variety of inpatient and outpatient, administrative and clinical data to all MTFs. CHCS II will be deployed soon.

- Medical Expense and Performance Reporting System (MEPRS) - The uniform health care cost management system for the Department of Defense (DOD). Provides detailed, uniform performance indicators, common expense classification, personnel utilization data, and a cost assignment methodology by individual work center.

- Corporate Executive Information System (CEIS) - The decision support target system that serves MTFs, Lead Agents, Military Departments and other DOD users. Provides standard tool sets for data extraction, compilation, manipulation, and management needs across the MHS.

- Health Enrollment Assessment Review (HEAR) - Provides baseline information on enrolled population concerning behavioral risks, utilization of services, need for clinical preventive services, and HCB perceived level of health. HEAR will be mandated for everyone in the next generation of MCS contracts (3.0).

- Health Risk Appraisal (HRA) Cardiovascular Screening System - Provides data that is used to evaluate the health and fitness status of the individual soldier and the soldier's unit through the identification of a risk lifestyle behaviors.

- Health Plan Employer Data and Information Set (HEDIS) 3.0 Performance Report – The industry accepted standard for measuring key aspects of a managed care organization to include: quality of care, utilization management, member access and satisfaction, financial assessment, and health plan management. The HEDIS serves as the basis for the MHS Report Card for the MTF.

- Uniform Chart of Accounts Personnel Utilization System (UCAPERS) – Provides personnel expense and manpower utilization data required by MEPRS.

- Defense Eligibility Enrollment Reporting System (DEERS) – Provides information for eligibility verification and ID card issuance for individuals entitled to Uniformed Services benefits.

NOTE: After August 2000, DEERS will also serve as the TRICARE Prime enrollment database of record and will issue enrollment cards (instead of the MCS contractors). Big changes in DEERs projected with DEERS 3.0.

GENERAL

- What systems are in place and who is responsible for the utilization/management of the systems? What is nursing's role related to data collection, entry, and accuracy?
- Who controls each of the systems mentioned? Who is involved in the various processes related to each system?
- What are the specific issues associated with each system? Who is the POC for these issues?
- What data can be retrieved from these systems? Where do the numbers come from and what do they mean? How do you interpret the data and use it in a meaningful way?
- Are data available that are specific to your HCBs or patient populations?
- What criteria are addressed on the MHS Report Card? What data are collected for inclusion on the MHS Report Card that are pertinent to your work center?
- What systems or processes integrate or cross talk?
- What reports are provided by the various systems in place?
- What is the process for getting copies of locally generated reports? Who prepares the requested reports? Where can the printed reports be obtained?
- Who receives copies of the various reports within/outside the facility? What decisions are affected by this data?
- Are data from your organization integrated with data from other MTFs in the region?
- How are the Health Risk Appraisal Program (HRAP) and HEAR related? How do they differ?
- How is information systems training obtained for clinic personnel?
- Who is the facility expert to provide technical or other assistance?
- Is there a help line? If so, how is it accessed? Who provides this service and what can you expect?
- At training sites, who has access to what data (students, residents, and temporarily assigned personnel)?

SECTION IX. REFERENCES

- American Nurses Association (ANA). 1995. *Nursing's Social Policy Statement.* Washington, DC: American Nurses Publishing.

- _____. 1991. *Standards of Clinical Nursing Practice.* Washington, DC: Author.

- _____. 1997. *Nursing in Ambulatory Care: The Future is Here.* Washington, DC: Author.

- _____. 1996. *Registered Professional Nurses and Unlicensed Assistive Personnel.* Washington, DC: Author.

- American Academy of Ambulatory Care Nursing Administration (AAACN). 2000. *Ambulatory Care Nursing Administration and Practice Standard*, (5th Ed.). Pitman, NJ: Jannetti.

- _____. 1997. *Telephone Nursing Practice Administration and Practice Standards.* Pitman, NJ: Jannetti.

- *Complete Guide to the Hospital or Ambulatory Survey Process*. Joint Commission. Oakbrook Terrace, IL: Author, current edition.

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace, IL: Author, current edition.

- _____. *Comprehensive Accreditation Manual for Ambulatory Care.* Oakbrook Terrace, IL: Author, current edition.

- The following journals/publications provide information reading:
  - The Journal of Ambulatory Care Management
  - Managed Care Journal
  - Case Management
  - Nursing Economics
  - AAACN Viewpoint
  - Inside Ambulatory Care
  - **TRICARE Standard Handbook**. 1997. (TSO 6010.46-H). TRICARE Support Office, Aurora, Colorado, 80045-6900.

- A great web site for textbooks and assorted journals is at http://www.armymedicine.army.mil/medcom/medlinet.

- The following official Army publications/documents are worthwhile clinic references:

  - AR 40-3, Medical, Dental, and Veterinary Care
  - AR 40-48, Non-Physician Health Care Providers
  - AR 40-66, Medical Record Administration and Health Care Documentation
  - AR 40-68, Quality Assurance Administration
  - AR 40-501, Standards of Medical Fitness
  - AR 40-562, Immunizations and Chemoprophylaxis
  - AR 50-5, Nuclear and Chemical Weapons and Materiel-Nuclear Surety
  - AR 40-6, Nuclear and Chemical Weapons and Materiel-Chemical Surety
  - AR 600-9, The Army Weight Control Program
  - AR 600-75, Exceptional Family Member Program
  - AR 601-142, Army Medical Department Professional Filler System
  - AR 623-105, The Officer Evaluation Report
  - AR 623-205, The Enlisted Evaluation Report
  - FM 21-20, Army Physical Fitness
  - MEDCOM Policy, “Ambulatory Procedure Visits (APV),” dated 13 September 1996
  - MEDCOM Circular 40-9, Medical Specialist (91B MOS) and Nursing Assistants (NA), dated 13 January 2000

APPENDIX
ACRONYMS AND ABBREVIATIONS

A

AAACN	American Academy of Ambulatory Care Nursing
AAR	After Action Report
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADS	Ambulatory Data System
ANA	American Nurses Association
APFT	Army Physical Fitness Test
APN	Advanced Practice Nurse
APU	Ambulatory Procedure Unit
APV	Ambulatory Procedure Visit

B

C

CBA	Clinical Business Area
CEEP	Capital Expense Equipment Purchasing
CHCS	Composite Health Care System
CHN	Community Health Nurse
CM	Case Management
CNA	Certified Nursing Assistant
COR	Contracting Officer Representative
COTR	Contracting Officer Technical Report
CPAC	Civilian Personnel Advisory Center
CPG	Clinical Practice Guidelines
CTT	Common Task Training

D

DEERS	Defense Eligibility Enrollment System
DNBI	Disease Non-battle Injury
DRG	Diagnosis Related Group

E

EBC	Enrollment Based Capitation
ED/EC	Emergency Department/Center
EMS	Emergency Medical Services
EPP	Emergency Preparedness Plan
ER	Emergency Room

F

FORSCOM	Forces Command

G

GME	Graduate Medical Education
GSU	Geographically Separate Unit

H

HBA	Health Benefits Advisor
HCB	Health Care Beneficiary
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCIL	Health Care Information Line
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employee Data Information Set
HMS	Health Management Strategies
HRAP	Health Risk Appraisal Program

I

IMD	Information Management Division
ITS	Immunization Tracking System

J

JCAHO	Joint Commission on Accreditation of Healthcare Organizations

K

L

LEAD	Leadership, Evaluation, and Development
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTHET	Long Term Health Education and Training

M

MASCAL	Mass Casualty
MEDCASE	Medical Care Support Equipment
MEPRS	Medical Expense and Performance Reporting System

MER	Management Employee Relations
MHS	Military Healthcare System
MOU	Memorandum of Understanding
MPT	Military Occupational Specialty (MOS) Proficiency Training
MTF	Medical Treatment Facility
MWR	Morale Welfare and Recreation

N

NA	Nursing Assistant
NAS	Non-availability Statement
NCOIC	Noncommissioned Officer in Charge
NCOPD	Noncommissioned Officer Professional Development
NP	Nurse Practitioner

O

OBD	Occupied Bed Days
OPD	Officer Professional Development

P

PAD	Patient Administration Division
PAO	Public Affairs Office
PCM	Primary Care Manager
PI	Performance Improvement
PICC	Peripherally Inserted Central Catheter
PIT	Performance Improvement Team
PHCA	Preventive Health Care Application
PHCS	Preventive Health Care System
POC	Point of Contact
PPIP	Put Prevention Into Practice
PR	Patient Representative
PROFIS	Professional Officer Filler System
PT	Physical Training

Q

QI	Quality Improvement

R

RMD	Resource Management Division
RN	Registered Nurse

S

SDS	Same Day Surgery
STD	Sexually Transmitted Disease

T

TAPES	Total Army Personnel Evaluation System
TDA	Table of Distribution and Allowances
TDY	Temporary Duty
TOE	Table of Organization and Equipment
TPCP	Third Party Collection Program
TRAC	TRICARE Regional Appointment Center
TSC	TRICARE Service Center

U

UAP	Unlicensed Assistive Personnel
UM	Utilization Management
UMR	Unit Manning Report
UR	Utilization Review
USAR	United States Army Reserve

V

VA	Veterans Affairs

W

X

Y

Z